Anthony Eden's (Lord Avon) Biliary Tract Saga

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Abstract: Anthony Eden (Lord Avon) was the youngest foreign secretary in Great Britain's history. He subsequently became Prime Minister, succeeding Winston Churchill. Eden had the misfortune to have, during cholecystectomy, a biliary tract injury which required four subsequent biliary tract operations. He was subject to recurrent fevers and postoperative disability at important times in his career and during international crises. This report details the operative procedures used and his clinical status at crucial times in national and international affairs.

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CLINICAL COURSE

On April 12, 1953, Robert Anthony Eden, the foreign Secretary of Great Britain, was scheduled for a cholecystectomy because of previous episodes of jaundice, abdominal pain, and the presence of gallstones. Up to this day, he had had a spectacular political career and a fortunate life. Born of landed gentry, he survived the trenches of World War I, a war in which 2 of 3 brothers were killed, as were one third of his class at Eton.[1] During the pre-World War II era, he had progressed up the greasy pole of politics[2] to become the youngest Foreign Secretary ever. Then in 1939, he abruptly resigned his post in protest of Chamberlain's policy of appeasement of Hitler and his country's lack of rearmament to meet the growing challenge.[3] All of this was achieved by unrelenting hard work and devotion to his country. His future in 1953 seemed assured, including a probable appointment as Prime Minister to succeed Churchill and a secure place in British history.

On that day in 1953, his good fortune was to change. The official cholecystectomy operative report did not note anything amiss with the procedure, but postoperatively he developed an external bile fistula and he became jaundiced with a serum bilirubin of 15 mg/dL. On April 29, he was reexplored. A large subhepatic bile collection was drained and an instrument was passed freely down the distal duct into the duodenum. No stone was encountered. The proximal duct was not identified. A T-tube was inserted into the distal duct and the operation terminated. After the second operation, the T-tube did not drain bile. A catheter was reinserted along the T-tube tract, and it drained bile for only several days. His jaundice relented, but he remained febrile. A catheter was reinserted into this drainage tract and a sinogram obtained on May 16. This showed a probable connection with the hepatic ducts and no dye in the duodenum (Fig. 1).

It so happened that Dr. Richard Cattell of the Lahey Clinic was in London in May 1953 speaking at a meeting of the Royal College of Surgeons. Cattell's reputation as a great technical surgeon, especially in the biliary tract, was recognized worldwide. Sir Horace Evans, Eden's physician, called in Dr. Cattell, who met with Eden and told him he needed another operation to repair the damage. Cattell preferred to do the procedure in his own surroundings, but there was pressure to operate in London. A meeting with Churchill was arranged at 10 Downing Street, at which time Churchill aggressively argued for a London operation. He stated that King George VI had been operated on the kitchen table at Buckingham Palace. After Cattell pointed out the enormity of Eden's operation, and that he needed his own operative and postoperative environment to obtain the best result, Churchill relented and with support from the majority of Mr. Eden's physicians and surgeons, it was agreed that Eden go to Boston for the required surgery (Cattell RB, personal communication).[4,5]

There were a few who objected. One minority opinion stated,[6] "I think I am one of the few people who know the facts there. Anthony Eden blew the ligature of his cystic duct and had a large bile collection, which had to be evacuated, but his common duct was not injured at all. When he left for America, his biliary fistula had dried up, he was not jaundiced and he was perfectly well.

The third operation was performed by Cattell June 10, 1953 at the New England Baptist Hospital, Boston, MA. A rubber drain was removed from the subhepatic space. A biliary-duodenal fistula was taken down and the duodenal opening closed. It is not unusual for spontaneous biliary tract-duodenal fistulas to form in these cases giving false

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FIGURE 1. Fistulogram suggesting partial filling of the hepatic ducts but not of the distal bile duct or duodenum.

hopes for normalcy. The liver was slightly enlarged, both lobes, with blunted edges. A very short segment of common hepatic duct was present, and both right and left ducts were probed and were not obstructed. Part of the septum between the ducts was clamped and incised to increase the diameter of the subsequent anastomosis. An end-to-side hepaticojejunostomy was performed, using a 16-Fr rubber Y-tube as a stent. An enteroenterostomy between the two jejunal loops completed the procedure. Recovery following this operation was uneventful.

He was then well until 1954, when he experienced fever and chills on one occasion and in 1955 on three occasions. None was severe or prolonged. In October 1956, he had a major fever to 106°F, which required hospitalization overnight. There were no further episodes until December of that year when several fevers were mild. Because of persisting episodes, he was readmitted to New England Baptist Hospital on April 7, 1957. All routine blood tests and liver function studies were normal, except that the bromsulphalein retention was 15%. A barium cholangiogram (which is not available) showed a patent hepaticojejunostomy with barium reflux into the biliary tree and subsequent free drainage. No Y-tube was seen, but since it was not radio opaque, it could still be in place and obstructed, requiring removal. Another operation on his biliary tract was performed on April 13, 1957 by Dr. Cattell. Both lobes of the liver were of normal size. The biliary anastomosis had an inside diameter of 7 mm when explored through an incision in the jejunum. His left hepatic duct accepted a number 6 Bâkes dilator. There was a markedly stenotic area in the right hepatic duct above the bifurcation, admitting only a 2-mm probe. The Y-tube was not present. The flow of bile was heavy from this duct after dilation, and there was a moderate amount of white mucoid material mixed with the bile. The duct was dilated with a "half point" clamp, as it would not accept a Bâkes dilator. Following the dilation, the opening in the jejunum was closed and a biopsy of the right lobe of the liver taken. The postoperative recovery was uneventful. The liver biopsy was reported as "no evidence of cholangitis or bile stasis."

Following the 1957 operation, he was free of symptoms suggestive of biliary tract problems for 3 years. However, beginning in 1960 and continuing until 1967, he was subject to febrile attacks occurring infrequently, only one with very high temperatures. From 1967 to 1969, he was free of attacks, but they recurred in 1969 with increasing frequency and severity. During this time, his liver function tests, complete blood counts, and ancillary studies were normal with the exceptions of an upper gastrointestinal series in 1965, which showed a probable enlarged left liver lobe (Fig. 2), a barium cholangiogram in 1969, which showed a possible obstruction of the right liver lobe anterior segment (Fig. 3), and one

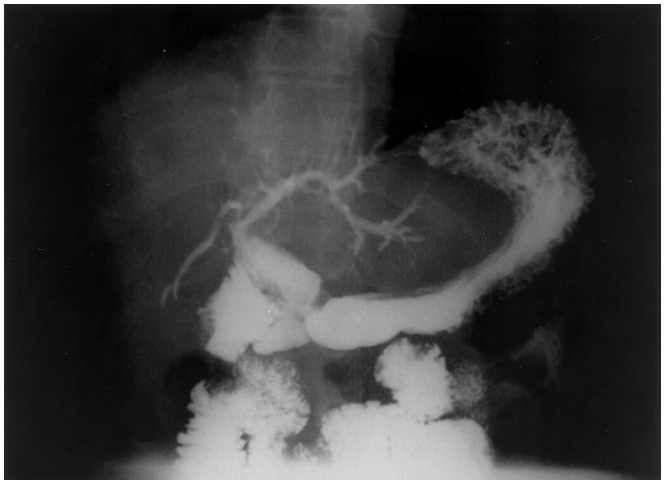

FIGURE 2. Barium upper gastrointestinal series obtained in 1965, which suggests an enlarged left lobe of the liver and a smaller right lobe.

FIGURE 3. Barium cholangiogram of 1969 with no visualization of the right anterior segment ducts. Reprinted with permission from *Surg Gynecol Obstet* (now *J Am Coll Surg*) 1972; 134:915–920.

alkaline phosphatase serum analysis, which was slightly elevated in 1969.

The fevers continued and he was reexplored on March 5, 1970 by the author. The findings at surgery were a small right liver lobe and enlarged left lobe. The biliary tree was explored through a small opening in the jejunum. There was a normal left duct, which accepted a #5 Bâkes dilator. There was difficulty in demonstrating the right duct and when found, it was dilated with difficulty up to a #6 Bâkes dilator. Hepatograms were then obtained, which showed leakage of dye into liver lobules of the right lobe and a cystic cavity in the anterior segment. (Fig. 4) A 12-Fr rubber catheter was placed transhepatically to exit skin and lie within the right duct, hepaticojejunostomy, and jejunum. The postoperative recovery was essentially uncomplicated.

In the years following the 1970 surgery, he was well, without significant biliary symptoms until 1975. At that time, he was having mild and infrequent fevers. His liver function tests were normal and a barium cholangiogram showed flow of the contrast into both ductal systems. A diagnosis of carcinoma of the prostate was made by needle biopsy and treatment was started.

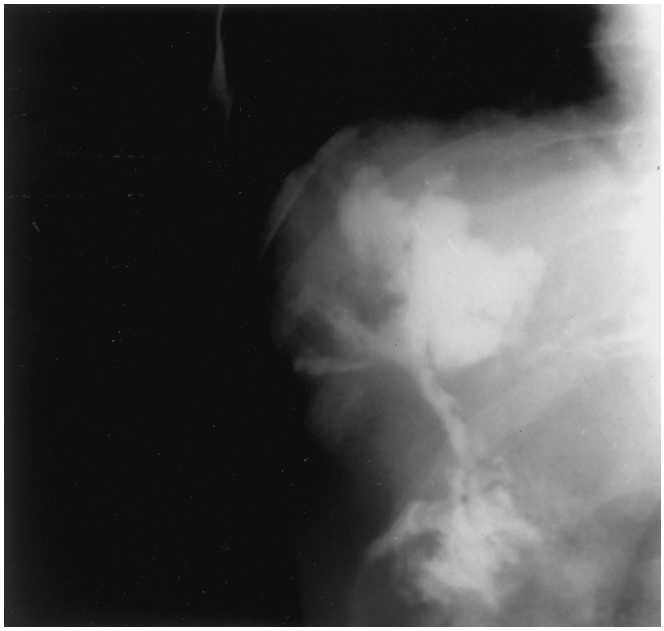

FIGURE 4. Intraoperative retrograde right anterior segment duct study showing leakage of dye into liver lobules and a cavity in the liver substance. Reprinted with permission from *Surg Gyn*ecol *Obstet* (now *J Am Coll Surg*) 1972;134:915–920.

He was hospitalized in 1976 for frequent fevers to 99°F and 100°F. His alkaline phosphatase was markedly elevated, probably due to widespread bone metastasis. His other liver function tests were normal. He died in 1977 with metastatic carcinoma of the prostate to bones and mediastinal nodes.

DISCUSSION

There are several interesting aspects of this biliary tract saga, some of which are geopolitical and others surgical. On June 23, 1953, Churchill had a stroke, causing a temporary paralysis, which raised a question if he should be replaced.[7,8] Eden was the natural successor, but he was recovering from Cattell's first operation at the time. His appointment as Prime Minister did come in April 1955, but if it had come in 1953, he would have had 2 more years of successful stewardship before the "no-win" Suez crisis.

In 1956, Nasser nationalized the Suez Canal. The canal was built by the French and partly owned by Great Britain. At that time, Britain had only 6 weeks of oil reserve, and one half of its supply came through the canal.[9] Eden's solution to the growing problem was to dispatch troops (with the French) to occupy the port cities and adjacent canal. On November 2, the General Assembly of the United Nations called for a ceasefire of the bombing of Suez targets and Egyptian air forces. The Anglo-French landings were on November 6 and the United Nation General Assembly called again for a ceasefire to be effective at midnight. Eden's support in the

.cabinet was reduced to three ministers, and the Eisenhower administration withdrew its support and made threats concerning Britain's oil supply and evaluation of the pound. In addition, the Soviets invaded Hungary. On November 7, the United Nations agreed to a police force in the Suez. On November 23, Eden left for Jamaica and returned December 14. Eden had ordered a troop recall, which was completed December 22. He subsequently resigned as Prime Minister.[10]

This sequence of events strongly suggests an important factor of illness in the decision-making during the crucial months of October, November, and December of 1956. Examination of Lahey Clinic and New England Baptist Hospital records, the Eden (Avon) papers at Birmingham University, and his biographies[10,11] revealed that the frequency and height of the fevers in 1956 were occasional and not severe until October 5, when one episode lasted 24 hours and his temperature reached 106°F. Subsequent fevers occurred in December 1956, but they were not as severe. Eden's physician, Lord Evans, advised him that he needed a rest because of feelings of extreme weakness following the October 1956 severe attack. He agreed and journeyed to Jamaica to recuperate.

There are legitimate questions concerning the selection of surgical procedures for biliary stricture repair. The 1950s, 1960s, and 1970s lacked adequate imaging techniques for the liver and biliary ducts. Certainly, barium cholangiograms following loop hepaticojejunostomy were not reliable for visualizing any ductal strictures proximal to the common hepatic duct anastomosis. At the time of his first and second stricture operation, it was realized that dilation of strictures was not as effective as excision and anastomosis, but the height of the stricture in the right lobe precluded another approach.

At the time of the third stricture operation, a right hepatectomy was considered, but in view of the shrunken right lobe with its accompanying rotation, the four previous operations in the area, the age of the patient, and other matters, it seemed wise to dilate and stent with a transhepatic tube, which could be left in place for a long period of time and even replaced. This approach led to the discovery of a possible abscess in the anterior segment of the right lobe of the liver. Some of the changes seen on the operative cholangiogram are due to excessive pressure on contrast injection, but the major area of dye accumulation seems to have an even outline, which is suggestive of a cavity in this anterior segment. Unfortunately, the transhepatic tube came out prematurely at about 3 months postoperatively. The symptoms and laboratory findings before stricture operations 2 and 3 were typical for unilateral lobar obstruction[12,13] but were also typical of a segmental liver abscess.

Anthony Eden (later Lord Avon) was an extraordinary person with high personal and national ideals and a drive for perfection in the discharge of his duties. As a patient, he was a model of cooperation and possessed an even humor at times of stress. It was a great tragedy that his career was savaged by surgical error.

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